

FUNCTIONAL ELIGIBILITY SCREEN FOR CHILDREN'S LONG - TERM SUPPORT PROGRAMS

Individual Information

Screen Information		
Screening Agency:		Referral Date (mm/dd/yyyy): / /
Screen Type (Check only one box): <input type="checkbox"/> 01 Initial Screen <input type="checkbox"/> 02 Annual Screen <input type="checkbox"/> 03 Screen due to change in condition or situation (or by request)	Screener's Name:	Screen Begin Date (mm/dd/yyyy): / /

Referral Source: (Check only one option.)			
<input type="checkbox"/> Parent(s)	<input type="checkbox"/> Child Care Provider	<input type="checkbox"/> Hospital, Clinic	<input type="checkbox"/> School
<input type="checkbox"/> Other Relative	<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Out-of-Home Setting	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Guardian (Non-Relative)	<input type="checkbox"/> Children with Special Health Care Needs	<input type="checkbox"/> Physician / Clinic	<input type="checkbox"/> Special Needs Adoption
<input type="checkbox"/> Self	<input type="checkbox"/> Family Support Program	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> State Center
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Therapist - Physical, Occupational or Speech Language Pathologist
<input type="checkbox"/> Birth-to-3 Program		<input type="checkbox"/> Public Health	
<input type="checkbox"/> Other - Please specify:			

Child's Basic Information		
<input type="checkbox"/> Primary Contact		
First Name:	Middle Name:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (xxx-xx-xxxx): - -	Birth Date (mm/dd/yyyy): / /
County / Tribe of Residence:		County of Responsibility:
Additional County / Tribe of Residence:		Additional County of Responsibility:

Are the child's parents aware of the legal concerns (e.g. Guardianship, Power of Attorney, and Representative Payee) once the child turns 18 years old?
<input type="checkbox"/> Yes
<input type="checkbox"/> No

U.S. Citizenship: (Check only one option.)

- | | |
|---|--|
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Hospital Birth Records |
| <input type="checkbox"/> Social Security Card | <input type="checkbox"/> Passport |
| <input type="checkbox"/> Alien Registration Number - Please specify: | <input type="checkbox"/> Social Security Document |
| | <input type="checkbox"/> Social Security Records or Checks |
| <input type="checkbox"/> Adoption Records | <input type="checkbox"/> State Department Records |
| <input type="checkbox"/> Baptismal Records | |
| <input type="checkbox"/> Citizenship Papers | |
|
<input type="checkbox"/> Other Acceptable Written Statement - Please specify: | |

Race [Optional] (Check all boxes that apply.)

- ☐ Black or African American
- ☐ Asian or Pacific Islander
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Other Race – Please specify: _____

Ethnicity [Optional]

Is participant Spanish / Hispanic / Latino?

- ☐ Yes
- ☐ No

If an interpreter is required, check language below (Check only one option.)

- | | |
|--|---|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Hmong |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> A Native American Language |
| <input type="checkbox"/> Other - Please specify: | |

Contact Information

Additional Contact 1		
<input type="checkbox"/> Primary Contact		
Contact Type (check only one option): <input type="checkbox"/> Parent <input type="checkbox"/> Non-legally Responsible Relative <input type="checkbox"/> Guardian of Person <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Representative Payee <input type="checkbox"/> Other – Please specify:		If Power of Attorney, check all applicable types: <input type="checkbox"/> Education <input type="checkbox"/> Financial <input type="checkbox"/> Health Care
First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
Best time to contact and/or comments:		

Additional Contact 2		
<input type="checkbox"/> Primary Contact		
Contact Type (check only one option): <input type="checkbox"/> Parent <input type="checkbox"/> Non-legally Responsible Relative <input type="checkbox"/> Guardian of Person <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Representative Payee <input type="checkbox"/> Other – Please specify:		If Power of Attorney, check all applicable types: <input type="checkbox"/> Education <input type="checkbox"/> Financial <input type="checkbox"/> Health Care
First Name:	Middle Initial:	Last Name:
Address:		
City:	State:	Zip:
Home Phone (xxx) xxx-xxxx:	Work Phone (xxx) xxx-xxxx:	Cell Phone (xxx) xxx-xxxx:
Best time to contact and/or comments:		

Additional Contact 3☐ Primary Contact**Contact Type (check only one option):**

- ☐ Parent
☐ Non-legally Responsible Relative
☐ Guardian of Person
☐ Power of Attorney
☐ Representative Payee
☐ Other – Please specify:

If Power of Attorney, check all applicable types:

- ☐ Education
☐ Financial
☐ Health Care

First Name:

Middle Initial:

Last Name:

Address:

City:

State:

Zip:

Home Phone (xxx) xxx-xxxx:

Work Phone (xxx) xxx-xxxx:

Cell Phone (xxx) xxx-xxxx:

Best time to contact and/or comments:

Additional Contact 4☐ Primary Contact**Contact Type (check only one option):**

- ☐ Parent
☐ Non-legally Responsible Relative
☐ Guardian of Person
☐ Power of Attorney
☐ Representative Payee
☐ Other – Please specify:

If Power of Attorney, check all applicable types:

- ☐ Education
☐ Financial
☐ Health Care

First Name:

Middle Initial:

Last Name:

Address:

City:

State:

Zip:

Home Phone (xxx) xxx-xxxx:

Work Phone (xxx) xxx-xxxx:

Cell Phone (xxx) xxx-xxxx:

Best time to contact and/or comments:

Child's Medical Insurance

Insurance Information (check all that apply, include policy number, and clearly write numbers)			
<input type="checkbox"/> Medicare	Policy Number:		
	<input type="checkbox"/> Part A	<input type="checkbox"/> Part B	<input type="checkbox"/> Medicare Managed Care
<input type="checkbox"/> Medicaid	Policy Number:		
<input type="checkbox"/> Railroad Retirement	Policy Number:		
<input type="checkbox"/> Private Insurance # 1 (includes employer-sponsored [job benefit] insurance)	Company Name:	Policy Number:	Individual Number:
<input type="checkbox"/> Private Insurance # 2 (includes employer-sponsored [job benefit] insurance)	Company Name:	Policy Number:	Individual Number:
<input type="checkbox"/> Other Insurance - Please specify:			
<input type="checkbox"/> No medical insurance at this time			

Primary Care Provider
<input type="checkbox"/> Does the child have a provider that meets most of his/her medical needs (primary care physician)?

If applicant has a primary care provider, please indicate type of provider:
<input type="checkbox"/> Adult Physician (Internist, Gynecologist, Adult Specialist) <input type="checkbox"/> Pediatric Specialist
<input type="checkbox"/> Family Practice Physician <input type="checkbox"/> Pediatrician
<input type="checkbox"/> General Practice Physician <input type="checkbox"/> Physician's Assistant
<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Other – Please specify:

Living Situation

Current Residence of the Child: (Check only one option.)

- | | | |
|---|---|---|
| <input type="checkbox"/> With Parent(s) | <input type="checkbox"/> Foster Care or Other Paid Caregiver's Home (e.g., 1-2 bed family home) | <input type="checkbox"/> Mental Health Institute/State psychiatric institution, Other IMD |
| <input type="checkbox"/> With Other Unpaid Family Member(s) | <input type="checkbox"/> Home/Apartment for which lease is held by support services provider | <input type="checkbox"/> No permanent residence (e.g., is in homeless shelter, etc.) |
| <input type="checkbox"/> With Legal Guardian | <input type="checkbox"/> ICF- MR/FDD | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Adult Family Home (1-2 bed) | <input type="checkbox"/> DD Center/State institution for developmental disabilities | <input type="checkbox"/> Treatment Foster Home |
| <input type="checkbox"/> Alone (includes person living alone who receives in-home services) | <input type="checkbox"/> Licensed Adult Family Home (3 bed) | <input type="checkbox"/> With Live-in Paid Caregiver(s) (includes service in exchange for room & board) |
| <input type="checkbox"/> CBRF (1-4 bed) | <input type="checkbox"/> Licensed Adult Family Home (4 bed) | <input type="checkbox"/> With Non-relatives/Roommates |
| <input type="checkbox"/> CBRF (5-8 bed) | | <input type="checkbox"/> With Spouse/Partner |
| <input type="checkbox"/> CBRF (more than 8 beds) | | |
| <input type="checkbox"/> Child Caring Institution | | |
| <input type="checkbox"/> Children's Group Foster Home | | |
| <input type="checkbox"/> Other (includes juvenile detention or jail) - Please specify: | | |

If the child is not currently living at home, is the child expected to return home within 6 months of screening date?

- ☐ N/A
☐ Yes
☐ No

If applicant is age 18 or older, record where the applicant prefers to live: (Check only one option.)

- | | | |
|---|--|--|
| <input type="checkbox"/> With Parent(s) | <input type="checkbox"/> CBRF | <input type="checkbox"/> Mental Health Institute/State psychiatric institution, Other IMD |
| <input type="checkbox"/> With Other Unpaid Family Member(s) | <input type="checkbox"/> ICF- MR/FDD | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> With Legal Guardian | <input type="checkbox"/> DD Center/State institution for developmental disabilities | <input type="checkbox"/> Paid Caregiver's Home (e.g., 1-2 bed adult family home, also includes service in exchange for room & board) |
| <input type="checkbox"/> Alone (includes person who receives in-home services) | <input type="checkbox"/> Home/Apartment for which lease is held by support services provider | <input type="checkbox"/> Residential Care Apartment Complex |
| <input type="checkbox"/> With Spouse/Partner | <input type="checkbox"/> Licensed Adult Family Home (3-4 bed AFH) | |
| <input type="checkbox"/> With Non-relatives/Roommates | | |
| <input type="checkbox"/> Unable to determine person's preference for living arrangement | | |
| <input type="checkbox"/> Other - Please specify: | | |

Guardian/Family's Preference of living arrangements for this individual: (Check only one option.)

- | | | |
|---|--|--|
| <input type="checkbox"/> With Parent(s) | <input type="checkbox"/> CBRF | <input type="checkbox"/> Mental Health Institute/State psychiatric institution, Other IMD |
| <input type="checkbox"/> With Other Unpaid Family Member(s) | <input type="checkbox"/> ICF- MR/FDD | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> With Legal Guardian | <input type="checkbox"/> DD Center/State institution for developmental disabilities | <input type="checkbox"/> Paid Caregiver's Home (e.g., 1-2 bed adult family home, also includes service in exchange for room & board) |
| <input type="checkbox"/> Alone (includes person who receives in-home services) | <input type="checkbox"/> Home/Apartment for which lease is held by support services provider | <input type="checkbox"/> Residential Care Apartment Complex |
| <input type="checkbox"/> With Spouse/Partner | <input type="checkbox"/> Licensed Adult Family Home (3-4 bed AFH) | |
| <input type="checkbox"/> With Non-relatives/Roommates | | |
| <input type="checkbox"/> Unable to determine person's preference for living arrangement | | |
| <input type="checkbox"/> Other - Please specify: | | |

For people 18 years and older who are not living with a parent or other family member, does the person have control over their living situation? (Check only one option.)

- | | |
|---|---|
| <input type="checkbox"/> Own the home | <input type="checkbox"/> Have control of the setting through a signed agreement with agency or provider. |
| <input type="checkbox"/> Hold the lease | <input type="checkbox"/> Have control of the setting through a condition of the provider's certification. |
| <input type="checkbox"/> Hold a co-Signed lease and have control over the physical environment | |
| <input type="checkbox"/> Work with an agency that holds the lease, but has control of the setting, and the right to hire and fire providers | |

Diagnoses

Has the child been determined disabled by the Disability Determination Bureau (DDB) or by the Social Security Administration?

- ☐ Yes
☐ No
☐ Don't Know

Transplanted Organ	Pending	Had On (mm/yyyy)
<input type="checkbox"/> Bone Marrow / Stem Cell	<input type="checkbox"/>	/
<input type="checkbox"/> Heart	<input type="checkbox"/>	/
<input type="checkbox"/> Intestine	<input type="checkbox"/>	/
<input type="checkbox"/> Kidney	<input type="checkbox"/>	/
<input type="checkbox"/> Liver	<input type="checkbox"/>	/
<input type="checkbox"/> Lung	<input type="checkbox"/>	/
<input type="checkbox"/> Pancreas	<input type="checkbox"/>	/

Child's Diagnoses: (Check all diagnoses that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Allergy
<input type="checkbox"/> Anemia, (e.g., Sickle Cell, Fanconi's)
<input type="checkbox"/> Anorexia Nervosa, Bulimia, or Other Eating Disorder
<input type="checkbox"/> Antisocial Personality Disorder
<input type="checkbox"/> Anxiety Disorder
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asperger's Syndrome
<input type="checkbox"/> Asthma
<input type="checkbox"/> Attention-Deficit Disorder, Attention-Deficit Hyperactivity Disorder, or Disruptive Behavior Disorder
<input type="checkbox"/> Autism or Autism Spectrum
<input type="checkbox"/> Bi-Polar Disorder
<input type="checkbox"/> Blind or Severely Visually Impaired
<input type="checkbox"/> Brain Disorder (Other than seizures) or Brain Damage
<input type="checkbox"/> Brain Injury – Traumatic (per statutory definition of TBI)
<input type="checkbox"/> Cancer
<input type="checkbox"/> Cardiac Condition
<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Cerebral Vascular Accident (CVA) (Pre- or Postnatal)
<input type="checkbox"/> Cognitive Disability
<input type="checkbox"/> Conduct Disorder
<input type="checkbox"/> Congenital Abnormality
<input type="checkbox"/> Contracture / Connective Tissue Disorder
<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Deaf or Severely Hearing Impaired
<input type="checkbox"/> Dehydration / Fluid or Electrolyte Imbalance
<input type="checkbox"/> Depersonalization Disorder
<input type="checkbox"/> Depression
<input type="checkbox"/> Developmental Delay
<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Digestive System Disorder (of mouth, esophagus, stomach, intestines, gall bladder, pancreas) | <input type="checkbox"/> Hemophilia / Other Blood Disorder
<input type="checkbox"/> Hypochondriasis or Body Dysmorphic Disorder
<input type="checkbox"/> Immune Deficiency
<input type="checkbox"/> Impulse – Control Disorder
<input type="checkbox"/> Infection – Current or Recurrent Infection
<input type="checkbox"/> Limb Missing, Severe Limb Abnormality, Arthrogryposis
<input type="checkbox"/> Liver Disease (Hepatic Failure, Cirrhosis)
<input type="checkbox"/> Mental Health Diagnosis – Other
Other: _____
<input type="checkbox"/> Metabolic Disorder
<input type="checkbox"/> Mood Disorder or Dysthymic Disorder
<input type="checkbox"/> Multiple Sclerosis or ALS
<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Muskuloskeletal Disorder
<input type="checkbox"/> Neuromuscular Disorder
<input type="checkbox"/> Nutritional Imbalance (e.g, Malnutrition, Vitamin Deficiencies)
<input type="checkbox"/> Obsessive – Compulsive Disorder
<input type="checkbox"/> Oppositional Defiant Disorder
<input type="checkbox"/> Paralysis Other than Spinal Cord Injury
<input type="checkbox"/> Paralysis – Spinal Cord Injury
<input type="checkbox"/> Personality Disorder
<input type="checkbox"/> Pervasive Developmental Disorder
<input type="checkbox"/> Post-Traumatic Stress or Acute Stress Disorder
<input type="checkbox"/> Prader-Willi Syndrome
<input type="checkbox"/> Prematurity / Low Birth Weight
<input type="checkbox"/> Renal Failure or Other Kidney Disease
<input type="checkbox"/> Respiratory Condition (other than Asthma)
<input type="checkbox"/> Rett's Syndrome
<input type="checkbox"/> Schizophrenia or Other Psychotic Disorder
<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Sensory Disorder (other than Blind or Deaf)
<input type="checkbox"/> Sexual and Gender Identity Disorder |
|--|---|

<input type="checkbox"/> Dissociative Disorder <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Endocrine Disorder (not Diabetes) <input type="checkbox"/> Failure to Thrive <input type="checkbox"/> Fetal Alcohol Syndrome / Effect <input type="checkbox"/> Genetic / Chromosomal Disorder <input type="checkbox"/> Genitourinary System Disorder	<input type="checkbox"/> Skin Disease <input type="checkbox"/> Somatoform Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Spinal Muscular Atrophy <input type="checkbox"/> Stereotypic Movement Disorder <input type="checkbox"/> Substance-Related Disorder, inc. Alcohol Abuse- (not to include Caffeine or Nicotine Addictions) <input type="checkbox"/> Substance Abuse Diagnosis – Other Other: _____ <input type="checkbox"/> Tourette's Syndrome <input type="checkbox"/> Tuberous Sclerosis <input type="checkbox"/> Wound, Burn, Bedsore, Pressure Ulcer <input type="checkbox"/> Other - Please specify:
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Mental Health/Substance Abuse

If the child has a clinical diagnosis of an emotional disability, has the diagnosis or symptoms related to that diagnosis, persisted for at least 6 months?

- ☐ Yes
- ☐ No
- ☐ Child does not have an emotional disability

If the child has a clinical diagnosis of an emotional disability, is the disability expected to last one year or longer?

- ☐ Yes
- ☐ No
- ☐ Don't Know

Does the child have any of the following symptoms? (Check all that apply.)

- ☐ Psychosis — Serious mental illness with delusions, hallucinations, and/or lost contact with reality
- ☐ Suicidality — Suicide attempt in past 3 months or significant suicidal ideation or plan in past month
- ☐ Violence — Life threatening acts
- ☐ Anorexia/Bulimia - Life threatening symptomology
- ☐ No symptoms apply

Does the child currently require any of the following services? (Check all that apply.)

- ☐ Mental Health Services
- ☐ Child Protective Services
- ☐ Clinical Case Management and Service Coordination Across Systems
- ☐ Criminal Justice system
- ☐ In-school Supports for Emotional and/or Behavioral Problems
- ☐ Substance Abuse Services
- ☐ No services required

If child currently receives or needs any of the above services, are supports, or would supports be more than 3 hours / week combined?

- ☐ Yes
- ☐ No

Are the psychosocial rehabilitation services the child needs for this diagnosis more than outpatient services (individual, group, or family) can provide?

- ☐ Yes
- ☐ No
- ☐ Does not apply

Behaviors

Is child currently an adjudicated delinquent?	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

Child's Behavior: (Check all that apply.)	
<input type="checkbox"/>	High-Risk Behaviors: Consistent lack of age-appropriate decision-making or judgment. May include risky behaviors such as unsafe social or sexual behaviors, substance abuse, running away, or walking into traffic. <input type="checkbox"/> Child is unable to understand risks. <input type="checkbox"/> Child is cognitively able to understand but still engages in high-risk behaviors.
<input type="checkbox"/>	Self-Injurious Behaviors: Head-banging, self-mutilation, polydipsia or pica
<input type="checkbox"/>	Aggressive or Offensive Behavior Toward Others: Includes aggressive behavior such as hitting, biting, kicking, spitting, or masturbating or disrobing in public. Also includes sexually inappropriate behavior toward children or adults.
<input type="checkbox"/>	Lack of Behavioral Controls: Lacks appropriate behavioral controls such that child can not be at home or in community settings without causing disruptions or distress to others: <input type="checkbox"/> Requires intervention weekly or less often. <input type="checkbox"/> Requires intervention more than once a week.
<input type="checkbox"/>	None of the behavioral problems apply at this time.

Social Skills: (Check all that apply.)	
<input type="checkbox"/>	Does not make eye contact.
<input type="checkbox"/>	Absence of or dramatic reduction of social interactions.
<input type="checkbox"/>	Unable to interpret other non-verbal cues (e.g. body language, facial expressions).
<input type="checkbox"/>	Does not have similar aged friends.
<input type="checkbox"/>	Excessive familiarity with strangers.

School and/or Work:	
<input type="checkbox"/>	Failing grades, repeated truancy, and/or expulsion, suspension, and/or inability to conform to school or work schedule more than 50% of the time.
<input type="checkbox"/>	Child needs in-school supports for emotional and/or behavioral problems.

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Please refer to separate document containing age-specific ADL and IADL questions.

Are any ADL/IADL functional impairments expected to last for at least one year from the date of screening?

- ☐ Yes
- ☐ No
- ☐ No ADL/IADLs have been checked

Child has a verified diagnosis that is expected to cause more substantial long term functional impairments within one or more of the following areas within one year: (Check all that apply.)

- ☐ Self-care
- ☐ Mobility
- ☐ Learning
- ☐ Communication

Work and School

Does the child's physical health or stamina level cause the child to miss over 50% of school or classes, or to require home education?

- ☐ Yes
☐ No

Is child currently attending high school?

- ☐ Yes
☐ No

What year is the child expected to leave school?

Year (yyyy):

**The following types of supports are expected for the child to prepare for leaving school:
(Check all that apply)**

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Section 504 Plan |
| <input type="checkbox"/> Not known at this time | <input type="checkbox"/> Transition Individual Education Plan (TIEP) |
| <input type="checkbox"/> Benefit Specialist | <input type="checkbox"/> Transition Services from the County |
| <input type="checkbox"/> Division of Vocational Rehabilitation (DVR) | |
| <input type="checkbox"/> Other expected supports – Please specify: | |

Current Employment Status

- ☐ Not employed
☐ Employed full time
☐ Employed part-time

Employment Interest

- ☐ Interested in new job
☐ Not interested in new job

If Employed, where: (Check all that apply.)

- ☐ Attends pre-vocational day/work activity program
☐ Attends sheltered workshop
☐ Has paid job in the community
☐ Works at home

Need for Assistance to Work: (Optional for unemployed persons.)

- ☐ Independent (with assistive devices if uses them)
☐ Needs help weekly or less (e.g., if problems arise)
☐ Needs help every day but does not need the continuous presence of another person
☐ Needs the continuous presence of another person

Health Related Services

Medical or Skilled Nursing Needs: (Check all that apply.)

- ☐ Rehabilitation program for brain injury or coma—minimum 15 hours/week
☐ Unable to turn self in bed or reposition self in wheelchair
☐ Recurrent cancer
 Date of Recurrence: _____ (mm/yyyy)
☐ Stage IV cancer
 Date of Stage IV Diagnosis: _____ (mm/yyyy)
☐ Terminal condition (prognosis < 12 months)
☐ Tracheostomy
☐ Ventilator (positive pressure)
☐ PT, OT, or SLP by therapist (does not include behavioral problems)
 ☐ Less than 6 sessions/week
 ☐ 6 or more sessions/week
☐ PT, OT, or SLP therapy follow-through: Exercise, sensory stim, stander, serial splinting/casting, braces, orthotics
 ☐ One hour a day or less
 ☐ More than 1 hour/day
☐ Wound, site care or special skin care
 ☐ One hour a day or less
 ☐ More than 1 hour/day

Place one check-mark per any row that applies.

		Frequency of Help / Services Needed			
HEALTH-RELATED SERVICES	Independ- ent with task	1 to 3 times/ Month	1 to 3 times/ Week	4 to 7 times/ week	2 or more times a day
Child has life-threatening incidents with sudden on-set.					
BOWEL or OSTOMY related SKILLED tasks: digital stim, changing wafer, irrigation (does not include site care).					
DIALYSIS: hemodialysis or peritoneal, in home or at clinic.	N/A	N/A			
IVs - peripheral or central lines - fluids, medications, and transfusions (does not include site care).					
OXYGEN and/or deep SUCTIONING - With Oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.					
RESPIRATORY TREATMENTS: Chest PT, C-PAP, Bi-PAP, IPPB treatments (does not include inhalers or nebulizers).					
TPN (Total Parenteral Nutrition) Does not include site care.					
TUBE FEEDINGS (does not include site care).					
URINARY CATHETER-RELATED SKILLED TASKS: straight caths, irrigations, instilling meds (does not include site care).					

How long have the skilled nursing needs and health related services selected above ALREADY lasted? (Check only one option.)

- ☐ Less than 6 months
☐ 6 to 12 months
☐ More than 12 months

**How long are the skilled nursing needs and health related services selected above EXPECTED to last?
(Check only one option.)**

- ☐ Less than 6 months from now
- ☐ 6 to 12 months from now
- ☐ More than 12 months from now

Risk

Risk Evident During Screening Process: (Check all that apply.)

- ☐ No risk factors or evidence of abuse or neglect apparent at this time.

Parents/caregivers' situation is at risk due to: (Check all that apply.)

- ☐ Difficulties in meeting the child's complex medical or health needs
- ☐ Difficulties in meeting the child's complex behavioral or mental health needs
- ☐ Parent's medical or health needs
- ☐ Parent's mental health needs
- ☐ Parent's substance abuse needs
- ☐ Domestic violence issues
- ☐ Involvement with the criminal justice system

Exacerbation: (Check all that apply.)

- ☐ Child's medical symptoms within last 12 months
- ☐ Child's behavioral or mental health symptoms within last 12 months

Other Concerns: (Check all that apply.)

- ☐ Behaviors place the child at risk of removal from home (or equivalent residence).
- ☐ The child has had a significant increase in the need for assistance in ADLs, IADLs, and/or health-related services over the last 3 months.
- ☐ The child has had a significant increase in the need for mental health services, juvenile justice system, in-school supports (for emotional and/or behavioral problems), and/or substance abuse services over the last 3 months.
- ☐ There are statements of, or evidence of, possible abuse, neglect, self-neglect, or financial exploitation.

If yes:

- ☐ Referring to CPS now
- ☐ Referring to APS now
- ☐ Competent adult refuses to allow referral to APS

Comments:

- ☐ The child's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months).

Functional Disability

This page screens the applicant for an expedited functional disability indicator:

Information below is based on: (check all that apply)

- ☐ Allowable documentation
- ☐ Parental report

Gestational Age and Birth Weight: (choose only one)

- ☐ Gestational Age of 37 to 40 weeks and weight at birth < 2,000 grams (4 lbs. 6 oz.)
- ☐ Gestational Age of 36 weeks and weight at birth <= 1,875 grams (4 lbs. 2 oz.)
- ☐ Gestational Age of 35 weeks and weight at birth <= 1,700 grams (3 lbs. 12 oz.)
- ☐ Gestational Age of 34 weeks and weight at birth <= 1,500 grams (3 lbs. 5 oz.)
- ☐ Gestational Age of 33 weeks and weight at birth <= 1,325 grams (2 lbs. 15 oz.)
- ☐ Any Gestational Age and weight at birth < 1,200 grams (2 lbs. 10 oz.)
- ☐ None of the above apply

Additional Diagnoses: (check all that apply)

- ☐ Amputation of a leg at the hip
- ☐ Malignant tumors except for brain or thyroid diagnosed within the past 2 years
Specify:

- ☐ Non-Hodgkin's lymphoma diagnosed within the last 2.5 years

Life-threatening congenital heart disease

- ☐ Coarctation of the aorta
- ☐ Complete AV canal defects
- ☐ Hypoplastic left heart syndrome
- ☐ Multiple ventricular septal defects
- ☐ Pulmonary atresia
- ☐ Tetralogy of Fallot
- ☐ Transposition of the great arteries
- ☐ Tricuspid atresia
- ☐ Other – Please specify:

Other catastrophic congenital abnormalities

- ☐ Anencephaly
- ☐ Cri-du-chat
- ☐ Cyclopia
- ☐ Tay-Sachs disease
- ☐ Trisomy D
- ☐ Trisomy E
- ☐ Other – Please specify:

The questions below will be dynamically displayed on the functional screen. Please check the boxes that apply to this applicant.

Blind or severely visually impaired

- ☐ Total blindness expected to last at least 12 months

Down Syndrome

- ☐ Excluding Mosaic

TPN (Total Parental Nutrition) does not include site care

- ☐ Expected to last at least 12 months

Tracheostomy

- ☐ Has already lasted at least 6 months
☐ Expected to last for at least 6 months from now

Tube feedings (does not include site care)

- ☐ Has already lasted at least 6 months
☐ Expected to last for at least 6 months from now

Uses a wheelchair or other mobility device not including a single cane

- ☐ Total duration at least 12 months

Ventilator (positive pressure)

- ☐ Expected to last at least 12 months

- ☐ I have reviewed this page and none of the questions apply to this applicant.

Screen Completion Time

Screen Completion Date (mm/dd/yyyy):
/ /

Time to Complete Screen	Hours	Minutes
Face-to-Face Contact with Person This can include an in-person interview, or observation if child cannot participate in interview.		
Collateral Contacts Either in-person or indirect contact with any other people, including other family members, advocates, providers, etc.		
Paper Work Includes review of medical documents, COP assessment, etc		
Travel Time		
Total Time to Complete Screen		

TRANSFER INFORMATION

To be completed after eligibility determination if applicant is referred to another program.

Referral date to service agency (mm/dd/yyyy): ____/____/____ Service Agency: _____